No. 95-1858

IN THE

Supreme Court of the United States

October Term, 1996

DENNIS C. VACCO, ATTORNEY GENERAL OF NEW YORK, ET AL.,

Petitioners,

v.

TIMOTHY E. QUILL, M.D., ET AL.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR RESPONDENTS

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QUESTION PRESENTED

May a State constitutionally criminalize a physician's prescription of medication requested by a competent, terminally ill patient in the final stages of dying, who seeks that medication to end her life without intolerable suffering, when the State permits terminally ill patients intentionally to end their lives by having their physicians withdraw or withhold essential medical treatment, including nutrition and hydration?

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INTRODUCTION

Seven years after the argument in *Cruzan* v. *Director, Mo. Dept. of Health*, 497 U.S. 261 (1990) — and two decades after *In re Quinlan*, 355 A.2d 647 (N.J.), cert. denied, 429 U.S. 922 (1976) — this Court is once again required to rule on laws that touch on fundamental issues of life and death. This case requires the Court to determine whether a State may forbid a terminally ill, mentally competent adult who is in the process of dying to end her own intolerable suffering, pain and physical disintegration by obtaining, within the context of the doctor-patient relationship, a prescription for medication that will allow her to end her life.

The law of New York evinces no blanket policy against a physician assisting such a terminally ill person in dying. Once a person reaches the final stages of life, New York always allows — as it sometimes does not for those whose conditions are reversible — the physician's termination of life-sustaining procedures, including the provision of food and water, even when the patient seeks such termination for the specific purpose of bringing about a merciful death. And for those dying patients willing to endure it, the State permits a procedure known as "terminal sedation" in which doctors induce a state of continuing unconsciousness — a "barbiturate coma" — wherein the patient is denied nutrition and hydration until he is dead. What the State does *not* permit is the provision of prescription drugs that would afford, to the dying patient who is suffering, a death that is certain, humane, and within his own control.

There can be no doubt about the profound nature of the liberty at issue in this case. The person who is dying in intolerable pain or torment faces "suffering [that] is too intimate and personal for the State to insist" that she must bear it. *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 505 U.S. 833, 852 (1992). In many of our religions and cultures, bearing such suffering at the end of life is seen as an "ennobl[ing]" act, involving pain that should — or indeed must — be borne "with . . . pride." *Id.* Many of us would never choose to take life-ending drugs, even were we terminally ill, debilitated and suffering intolerably on the edge of death. Nonetheless, in the United States the decision whether to die a death marked by such suffering must, to the degree fate and medicine permit, be left to the individual.

This is particularly true when suffering occurs in a life already artificially extended — as so many lives are today — through the use of modern technology. The Court recognized this in *Cruzan*, explicitly acknowledging the constitutional liberty of a "seriously ill or dying" patient who is being given food and water by artificial means such as a feeding tube — there, a woman in a persistent vegetative state — to instruct that such sustenance be withheld in order to hasten death. See *Cruzan*, 497 U.S. at 289 (O'Connor, J., concurring) (recognizing this liberty); see *id.* at 305 (Brennan, J., joined by Marshall and Blackmun, JJ., dissenting) (same); *id.* at 343-344 (Stevens, J., dissenting) (same); see also *id.* at 279 (opinion of the Court) ("the logic of [our prior] cases . . . embrace[s] . . . a liberty interest" in avoiding "artificially delivered food and water essential to life"). Just as "[a] seriously ill or dying patient whose wishes are not honored may feel a captive of the machinery required for life-sustaining measures or other medical interventions," *id.* at 288 (O'Connor, J., concurring), so a person who is suffering intolerably while dying, having been brought to this point by chemotherapy, an organ transplant, or some other technological advance, may well during her artificially prolonged death "feel a captive" of the State within the prison house of her own body.

Constitutional protection for the liberty asserted here is also compelled by "consideration of the alternative." *Casey*, 505 U.S. at 859. As the Court has made clear, the Liberty Clause protects the right to make certain "important decisions." *Id.* Protection of a choice either inheres or it does not — regardless of the *direction* in which the individual ultimately will seek to exercise it. With an aging population and increasingly fierce competition over medical resources, if there is no protected liberty on the part of a dying, terminally ill patient to decide whether or not to endure further pain or suffering, then the State may just as readily prohibit the provision of life-*extending* treatment to such patients as it may prohibit their receipt of life-*ending* medication. Cf. *id.* ("If . . . the woman's interest . . . had not been recognized . . . the State might as readily restrict a woman's right to choose to carry a pregnancy to term as to terminate it . . . ."). Petitioners chillingly foreshadow such a circumstance when they argue that "[t]he coming debate over the allocation of . . . medical resources . . . highlights the . . . illegitimate nature of a substitution of judicial judgment for that of

the elected representatives of a given state." Pet. Br. 26 n. 15.

Recognition of a dying patient's liberty, within the doctor-patient relationship, to request (and to decide whether or not to use) a prescription for life-ending medication does not imply — as petitioners and their *amici* worry it might — any general "right to die," or "right to suicide." The liberty for which respondents seek recognition, like Nancy Cruzan's liberty acknowledged by this Court six years ago, can exist only in truly hopeless cases. Just as Nancy Cruzan, when conscious, would not have been opting for "suicide" in deciding to end a life that would include no meaningful cognition at all, so a patient in the final stages of dying is not committing suicide when choosing to avoid only unbearable, consciousness-filling pain or suffering. Only in such cases is there a protected liberty because only in such cases does the patient face solely a choice of *how* to die, not a choice between death and the myriad possibilities of future life.

Nor would a "right" to involuntary euthanasia — if such a horrific thing could be imagined — follow from the liberty that respondents seek to vindicate. That liberty follows from recognition of the basic rights to human dignity and bodily autonomy. It would be a profound sacrilege to these rights for a person's life ever to be taken involuntarily by another. Indeed, it was precisely the importance of ensuring that such a decision be the individual's own that led this Court in *Cruzan*, addressing the case of a woman in a vegetative state who was no longer competent, to permit the State "to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements." 497 U.S. at 281.

Nor by any means do respondents seek to prohibit all state regulation in this area. Quite the contrary. Close regulation is required for many of the reasons put forward by petitioners and their *amici*. There is no doubt that power over life and death is subject to serious abuse — whether death is brought about by providing a lethal substance, or by disconnecting life-support machines. The state has compelling reasons to regulate closely *all* decisions intended to cause death, or taken with knowledge that they are more likely to hasten death than to extend life. This Court need not and should not make in this case what many have viewed as the mistake of *Roe* v. *Wade* — peremptorily pre-empting all state regulation

designed to advance society's important interests in this area. See, *e.g.*, Ginsburg, *Speaking in A Judicial Voice*, 67 N.Y.U. L. Rev. 1185, 1199 (1992).

The legal regime put in place by New York, however, is not a constitutional means of serving these interests. To begin with, the complete criminal prohibition of the prescription of life-ending drugs for mentally competent, terminally ill patients who are dying in unendurable pain and suffering unduly burdens those patients' constitutionally protected liberty.

Further, the State has not chosen a means of regulation that reasonably advances its asserted goals. For on the other side of the line drawn by the State — the permissible withdrawal of essential nutrition, hydration, respiration, kidney dialysis or other treatment for the purpose of bringing about death for those who are suffering intolerably in the process of dying — doctors are virtually unregulated. The line drawn by New York fatally undermines its claim that it has crafted its law to protect life in all circumstances or to prevent mistake or abuse.

Indeed, the only rationale that can explain the line drawn by New York is that the State prefers to send the (false) message that it does not tolerate *any* assistance in dying, despite the indisputable fact that physician assistance in dying (both lawful and unlawful) in fact goes on today. See Br. of Coalition of Hospice Professionals for Affirmance 15-17. The line drawn by New York serves only the impermissible purpose of permitting doctors to bring about death while maintaining plausible deniability — to the public at large, often to their patients and, perhaps, sometimes to themselves and one another.

But our nation is built upon the rule of law, not winks and nods. The State can have no cognizable interest in perpetuating a system that depends for its legitimacy on a gap between written and enforced law, especially if that gap makes it difficult for a patient to discuss honestly with her doctor what that doctor is doing with her body and, perhaps, her very life.

STATEMENT OF THE CASE

This action for declaratory and injunctive relief was decided on a motion for summary judgment. The facts are not in dispute; they

are contained in the pleadings and declarations filed in the District Court. See Pet. App. 65a.[1]

1. The Facts

The original plaintiffs were three physicians, Timothy E. Quill, Samuel G. Klagsbrun, and Howard A. Grossman, and three mentally competent terminally ill patients, Jane Doe, George Kingsley, and William A. Barth. An understanding of the intolerable pain and suffering that confronts such patients is the appropriate starting point for consideration of this case. Their declarations are set out in full at JA 106-108 (Jane Doe), JA 100-102 (George Kingsley) and JA 97-98 (William Barth). The declaration of Jane Doe, who was dying of thyroid cancer, gives a sense of their suffering:

> I am 76 years old and am a retired physical education instructor. . . . I also hold a Masters Degree in High School Guidance Counseling, which I earned from Queens College during the 1960s while I worked and cared for my children. I am widowed and have two grown children. I have always enjoyed an active and independent lifestyle. I have been a leader in my current retirement group school program and active in civic affairs.
>
> . . . . I have a large cancerous tumor which is wrapped around the right carotid artery in my neck and is collapsing my esophagus and invading my voice box. The tumor has significantly reduced my ability to swallow and prevents me from eating anything but very thin liquids in extremely small amounts. The cancer has metastasized to my pl[e]ural cavity

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[1] References to the decisions of the District Court and the Court of Appeals, as reprinted in the Appendix to the Petition for Certiorari, are styled "Pet. App. ___a." References to the Joint Appendix are styled "JA___." References to petitioners' brief in the Second Circuit are styled "Pet. Br. in CA2 at ___." References to the Brief in Opposition to the Petition for Certiorari are styled "Cert. Opp. ___." References to the Brief of Petitioners Vacco and Pataki are styled "Pet. Br. ___." References to the Brief of the United States as *amicus curiae* supporting petitioners are styled "Govt. Br.___." References to briefs *amicus curiae* are styled either "Br. of [the party] ___" or "[Party] Br. ___." References to briefs filed in *Washington* v. *Glucksberg*, No. 96-110, are identified by inclusion in the citation of the phrase "in *Glucksberg*."

and it is painful to yawn or cough. . . .

. . . . Because the tumor causes extreme difficulty in swallowing, I am constantly choking on my own saliva and mucous. At this time, I can no longer swallow sufficient food to nourish myself. It was recently recommended that I have a feeding tube surgically implanted into my stomach through which to receive nutrition and hydration. In early July 1994 I had the tube implanted and have suffered serious problems as a result. I have not tolerated the tube feeding well. . .

. . . . I take a variety of medications to manage the pain. . . . It is not possible for me to reduce my pain to an acceptable level of comfort and to retain an alert state.

I have experienced a variety of adverse side effects with each treatment regimen, including i) terrible scarring inside my throat and neck from surgery and radioactive iodine; ii) burning and swelling in my neck . . . and nausea from beam radiation; and iii) severe pain, vomiting, nausea and pressure associated with tube feeding.

I have pursued medical treatment since the time my cancer was originally diagnosed to the present time. . . . At this time, it is clear to me, based on the advice of my doctors, that I am in the terminal phase of this disease. It has been explained to me and I understand that there are no cures.

At the point at which I can no longer endure the pain and suffering associated with my cancer, I want to have drugs available for the purpose of hastening my death in a humane and certain manner. I want to be able to discuss freely with my treating physician my intention of hastening my death through the consumption of drugs prescribed for that purpose.

. . . . I believe it is my right to die peacefully and comfortably when I am terminally ill and suffering intolerably. I believe it is partly religious freedom and partly the pursuit of liberty and happiness guaranteed me by the United States Constitution. . . .

People should not be asked against their will to suffer unnecessarily in the process of dying when medical science could provide a humane death. To withhold such choice, and the means to exercise it, from those who are suffering is to deny me my right to live and die humanely. I see it as

unnecessarily cruel and inhumane to deny me this option. It is also inhumane to my loved ones, my family, to require them to watch helplessly as I am forced to endure such suffering.

JA 106-108 (paragraph numbers omitted).

George Kingsley, a 48-year old publishing executive dying from AIDS, submitted a declaration that described some of his suffering. He had "almost no immune system function," was going blind, and had several illnesses including "toxoplasmosis, a parasitic infection which has caused lesions to develop on my brain." JA 100. He took a number of prescribed medications daily that caused "constant negative side effects." These included "painful cramping, extreme gas with bloating and a total loss of appetite." One medication "[is infused] daily . . . for an hour through a Hickman tube," which "is connected to an artery in my chest, prevents me from ever taking showers, and makes simple routine functions burdensome." JA 100-101.

George Kingsley declared:

I know what it is like to lose control over one's life because of AIDS. I have witnessed the excruciating process of dying from AIDS many times over the past several years. One of my best friends recently died after an extended period of suffering in the final stages of AIDS. This friend desired to exercise the choice of hastening his death but did not have the means to do so humanely. The sound of him crying out in pain still echoes in my memory. I could do nothing to help him and he could do nothing to help himself.

My informed, rational choice is that my death from AIDS, when I reach the point where there is nothing more that medical science can do to halt the advance of my disease and I am living with intolerable pain and suffering, be as swift, painless and dignified as possible. I want to be able to hasten my own death in my own home, in a certain and humane way, surrounded with the people I love helping me make my passing comfortable and meaningful. I do not want my loved ones to watch me suffer needlessly.

JA 101-102 (paragraph numbers omitted).

The declaration of William Barth, a 28-year old former magazine

fashion editor, who was also dying of AIDS, was a virtual litany of suffering. He described his treatment for an opportunistic cancer with "radiation and chemotherapy," a virus "in my stomach and colon which caused severe diarrhea, fevers and wasting," one "parasitic infection for which there is effectively no treatment" which caused "significant additional wasting," a second "parasitic infection which has caused severe diarrhea, sometimes producing 20 stools a day, extreme abdominal pain, nausea and additional significant wasting," and from which "I have begun to lose bowel control," and, finally, "a form of tuberculosis which has caused yet additional wasting, fevers and night sweats." JA 97-98.

He described some of the treatment regimes to which he was subjected. One "required daily three hour home infusions." A second, begun after he "contracted AIDS-related pneumonia . . . was so extremely toxic that I vomited with each infusion." JA 97.

He concluded:

> . . . . While I have tolerated some [nightly intravenous] feedings [to attempt to stop the wasting], I am unwilling to accept this for an extended period of time. . . . I can no longer endure the pain and suffering . . . and I want to have drugs available for the purpose of hastening my death.

JA 98.

Palliative medication is of course available to ease many patients' physical pain. But it is undisputed that for others, especially those dying of some forms of cancer and those particularly near death, it may be impossible to relieve their excruciating pain or other physical symptoms. JA 45 (Declaration of Timothy Quill, M.D.); Cherny & Portenoy, *Sedation in the Management of Refractory Symptoms: Guidelines for Evaluation and Treatment*, 10 J. Palliative Care 31 (1994). In addition, some patients may be unable to receive relief from pain because of their violent physical or psychological reactions to high doses of opiates. Palliative medication also has no effect on the suffering that may be brought on by a patient's own anguish, physical degeneration and loss of dignity. JA 46 (Quill Declaration); Cherny & Portenoy at 31. Further, at levels at which it may be effective, such medication may have the effect of impairing mental acuity. See JA 107 (Doe Declaration). Many patients find — especially near the end — that they cannot obtain

the required level of pain relief before losing whatever clarity of mind is otherwise left to them for communicating with loved ones, praying, or coming to terms with their impending death. Although these patients may be prepared to die, they are confronted instead only with intolerable suffering — the suffering of their own pain or of opiate-induced oblivion. See JA 45 (Quill Declaration).

All three of the named patient-plaintiffs died before the district court rendered its decision. JA 198. Significantly, "[t]he State of New York did not contest below, nor does it contest now, the depth of the suffering experienced by these plaintiff-patients." Pet. Br. 5.

The physician-plaintiffs alleged that they each "trea[t] patients who are terminally ill and experience chronic, intractable pain and/or intolerable suffering," and that "in the regular course of [their] medical practice" some of these patients "request assistance in the voluntary self-termination of life." JA 160-161 (Amended Complaint). Each alleged, and petitioners do not contest, that "[u]nder certain circumstances it would be consistent with the standards" of his "medical practice to assist these patients in their decision to hasten death through the prescription of medications," and that this assistance represented the only "certain and humane" manner in which these patients could die. *Id.*

Each physician-plaintiff filed a declaration describing the type of "medical treatment . . . I seek to be able to give my patients." JA 116 (Supp. Dec. of Dr. Quill); JA 121 (Supp. Dec. of Dr. Klagsbrun); JA 123 (Supp. Dec. of Dr. Grossman). Each declared that he sought the ability to "fulfill my professional obligations," by being permitted "to prescribe drugs, if and when medically and psychiatrically appropriate," JA 116; JA 121; JA 123, for his competent, terminally ill patients who wanted to be able to take them in order to prevent "prolonged suffering . . . if and when their suffering becomes intolerable." JA 190 (Second Supp. Dec. of Dr. Quill); JA 192 (Second Supp. Dec. of Dr. Klagsbrun); JA 194 (Second Supp. Dec. of Dr. Grossman). Each physician-plaintiff sued not only on his own behalf, but on behalf of his mentally competent, terminally ill patients with "chronic intractable pain and/or intolerable suffering," who seek "to make decisions about the end of their lives, including the right to choose to hasten inevitable death with suitable physician-prescribed drugs" in order to "avoid continued suffering and a lingering, painful death." See JA 158-163

(Amended Complaint).[2]

2. The Law of the State of New York

The law of New York provides that "[a] person is guilty of manslaughter in the second degree when . . . [h]e intentionally causes or aids another person to commit suicide." N.Y. Penal Law § 125.15(3). It also provides that "[a] person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide." N.Y. Penal Law § 120.30. The interaction of these criminal statutes with end-of-life medical decisions under New York law requires some description.

Petitioners suggest that under New York law the refusal of life-sustaining medical treatment, including nutrition and hydration, has nothing to do with suicide — that it merely involves exercise of the right to "avoi[d] unwanted bodily intrusion." Pet. Br. 30; *id.* at 11, 13-19. But that is not so. To be sure, the refusal of life-sustaining treatment, or a request for its withdrawal, is not *generally* treated by New York law as "suicidal" even if it will foreseeably (or, indeed, inevitably) end in death. To reach this result, New York law utilizes a legal fiction concerning intent. See, *e.g.*, *Delio* v. *Westchester County Medical Center*, 516 N.Y.S. 2d 677, 692 (App. Div. 1987) ("[S]uicide requires a specific intent to die which has generally been found lacking in patients who refuse artificial life-sustaining medical treatment. Instead, a person's desire to have artificial life-support systems terminated evinces only an intent to live free of unwanted mechanical devices and permit the processes of nature to run their course.") (citations omitted).

Nonetheless, persons who are neither terminally ill nor suffering from an incurable condition that renders cognitive life impossible

[2] Plaintiffs Doe, Kingsley and Barth, and these other patients will be referred to collectively as the "patient-plaintiffs." One of the physician-plaintiffs "has had a criminal proceeding instituted against him in the past," Pet. App. 15a. The Second Circuit concluded the physician-plaintiffs here "fac[e] the threat of prosecution," that they may raise the rights of their patients, and that therefore there is a justiciable controversy. Pet. App. 15a. Accord *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52, 62 (1976). The death of the named patient-plaintiffs thus does not affect the justiciability of this cause.

(*e.g.*, a persistent vegetative state) may be forced to accept life-sustaining medical treatment under certain circumstances. New York's law *will* inquire into their intent to the extent that, if the injury that led to the need for treatment is found to be self-inflicted or the refusal of treatment or request for withdrawal is found to be motivated by a desire to die, the refusal or request for withdrawal may be treated as a suicidal act and hence denied. See *Fosmire* v. *Nicoleau*, 551 N.E.2d 77, 82 & n. 2 (N.Y. 1990) (right of young, otherwise healthy mother who had just delivered by caesarian section to refuse life-saving blood transfusion that would have "completely restore[d her] health" upheld only because "the injury here was not self-inflicted nor does the patient want to die"); see also *Van Holden* v. *Chapman*, 450 N.Y.S.2d 623, 625, 626-627 (App. Div. 1982) (mentally competent adult has no right to refuse nutrition "intravenously or by means of a nasal gastric tube" when his intent is to starve himself to death).

In these latter circumstances, a doctor who assisted the person by, for example, withdrawing essential medical treatment at that person's request would be subject to prosecution under the assisted suicide laws just as if he had provided a lethal prescription. While "merely declining medical care, even essential treatment, is not considered a suicidal act or indication of incompetence," *Fosmire*, 551 N.E.2d at 82, "[t]he State will intervene to prevent suicide," *id.* (citing *inter alia* N.Y. Penal Law § 35.10[4]).[3]

This is by no means illogical. The intentional and nonconsensual disconnection or termination of life-sustaining treatment by a physician would clearly amount to murder under state law. See *Grace Plaza of Great Neck, Inc.* v. *Elbaum*, 588 N.Y.S.2d 853, 857 (App. Div. 1992), aff'd, 623 N.E.2d 513 (N.Y. 1993). Similarly, assisting one whose specific intent was to kill himself by the disconnection or termination of some life-sustaining treatment to which he happened temporarily to be connected could violate New York's law against aiding in suicide. Cf. U.S. Catholic Conference,

[3] New York Penal Law § 35.10[4] provides that "[a] person acting under a reasonable belief that another person is about to commit suicide . . . may use physical force upon such person to the extent that he reasonably believes it necessary to prevent such result."

et al. Br. 20-21.

The situation is very different for those patients who are "fatally ill with no reasonable chance of recovery," see *Matter of Storar*, 420 N.E.2d 64, 66 (N.Y.), cert. denied, 454 U.S. 858 (1981), who are receiving life-sustaining treatment, and who seek to die through withdrawal of that treatment:[4] For them the State simply does not inquire into intent. In this terminal-illness context, the applicability of the "assisted suicide" law is conclusively reasoned away by the legal fiction that one who "ch[ooses] . . . a natural death," Cert. Pet. 9, through the withdrawal of life-sustaining treatment simply does not have the "intent to die." As petitioners concede before this Court, although the provision of life-ending medication is flatly forbidden to a suffering, terminally ill patient whose intent is to cause death, "terminally ill people may request the withdrawal of life-sustaining treatment," *even to end their lives*, in circumstances where, but for their incurable illness, the State would treat the request as a plea for assistance in committing suicide. Pet. Br. 3; Cert. Pet. 9. See, *e.g.*, *In the Matter of Lydia Hall Hospital*, 455 N.Y.S.2d 706, 709, 711 (Sup. Ct. Nassau County 1982) (competent "terminal[ly] il[l]" diabetic who "said he was suffering so much, he wanted to die" may terminate life-sustaining dialysis).

In sharp contrast, New York applies the *opposite* presumption (namely, of "suicidal" intent) for those terminal patients who would end their suffering through the self-administration of life-ending medication. Pet. Br. 15. But, as petitioners acknowledge, a physician may lawfully assist a terminally ill patient to end life through withdrawal of life-sustaining treatment even when that patient has *precisely the same intent* as the patient-plaintiffs here who seek a physician's prescription for life-ending medication. See Pet. Br. 15-16 (arguing only that the "purpose" of one who lawfully "terminates treatment . . . *may* . . . not [be] death"); see also *In the Matter of Lydia Hall Hospital*, 455 N.Y.S.2d at 709, 711.

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[4] This description covers those who are terminally ill as well as those who suffer from conditions that drastically degrade life and that will not be cured or improved by the life-sustaining treatment. See, *e.g.*, *Delio* 516 N.Y.S.2d at 683 (right to withdrawal of food and water upheld for patient in persistent vegetative state who can breathe on his own and would, if given nutrition and hydration, remain alive indefinitely).

The purpose of the intentionally life-ending procedure is, in both cases, to "reliev[e] the patient's pain and suffering." Pet. Br. in CA2 at 27 (describing the supposed intent behind lawful withdrawal of life-sustaining treatment). And the patient-plaintiffs in this case — in precisely the same sense as those terminal patients on life-support who request the withdrawal of life-sustaining treatment — "fervently wish to live," Pet. Br. 16 (internal quotation marks and citation omitted). See, *e.g.*, JA 107 (declaration of Jane Doe) ("I have pursued medical treatment since the time my cancer was originally diagnosed to the present time."); JA 98 (declaration of William Barth) ("Since I was diagnosed HIV-positive I have received medical treatment. I believe that I have received good treatment and have benefitted from it."). Indeed, any suggestion to the contrary is profoundly offensive.

Thus, as the Second Circuit observed, "New York law does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths." Pet. App. 24a. In cases in which withdrawal of life-sustaining respiration, food or water is involved, the "New York Court of Appeals" has "recognized the right of a competent, terminally-ill patient to hasten his death upon proper proof of his desire to do so." See Pet. App. 25a. Cf. *e.g. Eichner* v. *Dillon*, 426 N.Y.S.2d 517, 537, 539 (App. Div. 1980), aff'd with modifications, 420 N.E.2d 64 (N.Y.), cert. denied, 454 U.S. 858 (1981) (the "State['s] . . . interest in discouraging irrational and wanton acts of self-destruction" is not implicated when "the terminally ill but competent individual . . . chooses not to resist death and to die with dignity"). But "those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs." Pet. App. 30a.[5]

Under New York law, the intentionally life-ending acts of those terminally ill patients who do not depend on life-sustaining treatment

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[5] Petitioners have not challenged the Second Circuit's construction of New York law. This Court in any event ordinarily defers to the lower federal courts' interpretations of state law — unless they amount to "plain" error — because the lower courts are "better schooled in and more able to interpret the laws of their respective States." *Brockett* v. *Spokane Arcades, Inc.*, 472 U.S. 491, 499-500 & n. 9 (1985).

are *deemed* "assisted suicide" by the State; the intentionally life-ending acts of those terminally ill patients who *do* depend on such treatment could also be so deemed, but they never are.

Petitioners argue that the "right of a competent adult patient to decline medical treatment . . . cannot be characterized as one to 'hasten death.'" Reply to Cert. Opp. 3. But the government's "characterization" of its actions cannot control "for constitutional purposes." *Colorado Republican Campaign Committee* v. *FEC*, 116 S.Ct. 2309, 2319 (1996) (Breyer, J., joined by O'Connor and Souter, JJ.). What matters is that, at least for the terminally ill patient in the process of dying, New York permits active physician assistance in deliberately bringing about death by the withdrawal of life-sustaining treatment — a withdrawal that, if undertaken without consent, would amount to homicide, and that, if undertaken deliberately to assist the death of an individual being treated for a condition from which recovery was expected, could be subject to prosecution for criminal assistance of suicide.

Patient-plaintiff Jane Doe, like some other terminal patients in the final stages of their illness, thus had lawfully available to her one method of physician assistance in ending her suffering. Because she required a feeding tube for nutrition and had had one surgically inserted, she could have asked to have it removed without running afoul of New York's assisted suicide laws.

But while this would have permitted Jane Doe to die with her physician's assistance before her cancer ravaged her further, she would have been subject to what for her would have been the degrading process of death by starvation. See JA 86 (Grossman Dec.) (describing "starvation and dehydration" as "an excruciating process that may continue for weeks"). She (and her family) would have been relegated to watching — perhaps only in glimpses as she was roused from a stupor brought on by malnutrition or medication or both — the degeneration of her body unto death.

For those who have a respirator removed, the state-approved process of dying is even more terrifying than it would have been for Jane Doe. "Since dying of respiratory failure can be one of the most excruciating and frightening deaths possible," JA 117 (Quill Supp. Dec.), doctors provide morphine or barbiturates to ease panic, air hunger, and the sense of suffocation, leaving patients — sometimes for weeks — in a "twilight state . . . before eventually dying." *Id.*

The administration of such drugs is lawful, even though it is undisputed that they can hasten death. *Id.* This is permitted in New York because of the familiar (but loosely applied) "double effect" principle, which applies to all patients, whether or not they are on life-sustaining treatment.

Petitioners concede that under this principle doctors may administer drugs with the "intent . . . to relieve pain and suffering" even with the foreseeable effect — indeed, the overwhelming likelihood — of causing death. See Pet. Br. 15-16 n. 9. But they may not provide medication at the request of the patient for the *purpose* of hastening death, even to end suffering in the final stages of terminal illness. See Pet. Br. in CA2 at 27.

Double effect, by relying on the fiction that the clearly foreseeable consequences of an act are not intended, often permits doctors deliberately to cause death, but because the provision of drugs for the same purpose remains criminal in all circumstances, the law prevents open consultation with the patient, the family and other physicians. Frighteningly, in these circumstances — unlike a legal regime in which open consultation about life-ending medication is permitted — "[j]ustification by double effect . . . may function as a 'fig leaf' for euthanasia." Truog, Berde, Mitchell and Grier, *Barbiturates in the Care of the Terminally Ill*, 327 New Eng. J. Med. 1678, 1680 (1992) ("Truog, *et al.*").

Finally, even those who are *not* connected to any sort of life-sustaining device are permitted, within the lines drawn by New York law, to obtain active physician assistance in ending their lives — so long as they employ another particularly gruesome method: "terminal sedation." See, *e.g.*, Rousseau, *Terminal Sedation in the Care of Dying Patients*, 156 Arch. Intern. Med. 1785, 1785-1786 (1996); see Pet. Br. in CA2 at 27.

"As the end of life approaches, th[e] relief of physical and psychological symptoms can become more difficult." Cherny & Portenoy, 10 J. Palliative Care at 31. Terminal sedation is sometimes "prescribed" for those whose misery is too great, either because of the "twisting and racking pain that invades, dominates and shrivels their consciousness, that leaves them no psychic or mental space for the things they want to think and say and do before they die," Roy, *Need They Sleep Before They Die?*, 6 J. Palliative Care 3 (1990), or because of "suffering related to existential or

spiritual concerns" that "cannot be adequately controlled despite aggressive efforts to identify a tolerable therapy." Cherny & Portenoy at 31.

Using heavy sedation or anesthesia, the doctor places the patient in "a sleep-like state" for "the last days or weeks of life." American Medical Association, *et al.* ("AMA") Br. in *Glucksberg* 6. Two authors from New York's Memorial Sloan Kettering Cancer Center describe the effect as "[t]he loss of interactional function." Cherny & Portenoy, 10 J. Palliative Care at 31. This type of "sedation" is also referred to by medical professionals as a "barbiturate coma." Truog, et al. at 1679.

Once a patient is in that deathlike state, which the doctor may maintain by a continuous infusion of barbiturates, benzodiazepines or other anesthetics at doses that will keep him unconscious, see *id.*, the patient is entitled under state law to fulfillment of his previously expressed desire to refuse "artificial nutrition and hydration." American Geriatrics Society ("AGS") Br. 7 (footnote omitted). Since with "sedation and withdrawal of treatment," AMA Br. in *Glucksberg* 10, the patient's IV tube will be delivering only unconsciousness and no food or water, the patient's body tissues and vital organs deteriorate, causing death within seven to ten days. JA 117 (Quill Supp. Dec.).

It is clear that under New York law the terminal sedation option is available to all who are terminally ill and who find their situation intolerable.[6] Indeed, it has been estimated that between 5% and 52% of dying patients "develo[p] intolerable symptoms that requir[e] terminal sedation for terminal relief." Rousseau, 156 Arch. Intern. Med. at 1785. "[S]edation can always eliminate symptoms in persons near death. This course is available at present, without any change in the law . . . ." AGS Br. 25; see also New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* 40, 92-94, 164 (1994) ("New York Task Force Report").

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[6] See N.Y. Penal Law §120.05(5) (otherwise applicable criminal assault statute does not apply when one "intentionally causes stupor [or] unconsciousness" if this condition is induced with "consent" or for a "medical or therapeutic treatment").

Of course, as even the AGS acknowledges in a remarkable understatement, "some may view such treatment as undesirable." AGS Br. 25; see also New York Task Force Report at 93-94 & n. 60. Indeed. Some may think it monstrous to have their minds chemically shut down and to be imprisoned in their decaying bodies and deliberately starved to death, while loved ones keep a gruesome vigil. Even aside from the fact that patients put to sleep in this way may still perceive their surroundings and feel great pain, Resp. Br. in *Glucksberg* 22 n. 13, some patients may deem the whole procedure an assault on their humanity and the very essence of degradation.

To the patients who regard this permitted last resort as horrifying, the only reply given by petitioners and their *amici* is that the "social cost of accommodating their preference for physician-assisted suicide over sedation and withdrawal of treatment is likely to be high." AMA Br. 10.

3. The Proceedings Below

The District Court granted summary judgment for petitioners. Pet. App. 63a. The Second Circuit reversed. Pet. App. 1a. Contrary to the conclusion of the Ninth Circuit in *Compassion in Dying* v. *Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc), cert. granted *sub nom. Washington* v. *Glucksberg*, No. 96-110, the Second Circuit held that, "in the absence of a clear direction" from this Court, it could not recognize a constitutionally protected liberty in this case. Pet. App. 16a-20a. The court, however, struck down on equal protection grounds the ban on physician provision of life-ending medication, concluding that

> New York does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs.

Pet. App. 29a-30a. The court held that

> to the extent [the statutes] prohibit a physician from prescribing

medications to be self-administered by a mentally competent, terminally ill person in the final stages of his terminal illness they are not rationally related to any legitimate state interest.

Pet. App. 35a.

Judge Calabresi concurred in the result. He concluded that "for many, many years" the State legislature "has not taken any recognizably affirmative step reaffirming the prohibition of what [plaintiffs] seek." Pet. App. 44a. Consequently, "on the current legislative record" he found a violation of both due process and equal protection. Pet. App. 62a. He would, however, have left open the possibility of reconsideration of the constitutional question "were New York to reenact [the prohibitions] while articulating the reasons for the distinctions it makes in the laws, and expressing the grounds for the prohibitions themselves." Pet. App. 62a.

SUMMARY OF ARGUMENT

I. Under the procedure for defining the scope of Fourteenth Amendment Liberty described by the controlling opinion in *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 505 U.S. 833 (1992), the liberty at issue in this case deserves constitutional protection. It implicates a constellation of interests each of great constitutional moment; these interests have played animating roles in this Court's previous Liberty Clause decisions. Indeed, if *Casey* is to remain defensible as a principled explication of protected liberty, the protected nature of the patient's decision at issue here must be recognized.[7]

II. The legal regime at issue in this case unduly burdens that constitutionally protected liberty. Not only does it present a virtually

[7] Petitioners have framed the Questions Presented in this case to address only equal protection principles. As prevailing parties in the Court of Appeals, respondents are of course entitled to "defend [their] judgment on any ground properly raised below." *Washington* v. *Yakima Indian Nation*, 439 U.S. 463, 476 n. 20 (1979). Consequently, and in the hope that our analysis of this question will be useful to the Court, respondents also urge affirmance of the judgment below on Liberty Clause grounds. Respondents have "pressed this issue throughout the litigation," *id.*, and "presented [it] as a basis upon which the judgment below should be sustained." *Id.* See Cert. Opp. 22 n. 8.

insurmountable obstacle to the exercise of protected liberty, it is not a reasonably tailored means of advancing any of the State's important interests in this area.

III. The legal regime here also violates equal protection. Neither the distinction between those who are on life-support and those who are not, nor the distinction between legally permitted and forbidden methods of physician assistance in dying, can survive even rational-basis scrutiny.

ARGUMENT

I. THE FOURTEENTH AMENDMENT PROTECTS THE LIBERTY AT ISSUE IN THIS CASE

This Court has held that the Constitution protects from governmental intrusion an individual's right to make certain profound, life-shaping decisions. Those decisions that "involv[e] the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment." *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 505 U.S. 833, 851 (1992). The final, life-shaping choices which a dying person is capable of making — so that, to the degree medically possible, the person's dying will be free of unbearable pain and suffering and will not destroy the dignity and integrity of that person as a human being — are solidly encompassed within that liberty. Indeed, if *Casey* and this Court's other holdings construing "the substantive sphere of liberty which the Fourteenth Amendment protects," *Casey*, 505 U.S. at 848, are to be understood as principled decisions, the Court must recognize the protected nature of this profoundly personal dimension of liberty.

Petitioners and their *amici* argue that recognition of the right asserted in this case will lead inevitably to recognition of a general right to die, a broad right to choose the timing and manner of one's death, or a right to physician-assisted suicide. But respondents do not urge recognition of any such broadly-defined liberty. The right asserted here is distinguishable in principle from those which concern petitioners. A patient who is in the final stages of terminal illness and who seeks to avoid a death marked by intolerable pain and suffering faces unique circumstances. The choice of how to die

is the only choice left to him. An individual whose only options are those visible from a misery-drenched deathbed has no freedom left, no control over his life at all, if the management of this choice — meager though it may seem to the healthy — is deemed to be within the plenary control of government.

For such a person, the ability to make that choice in the context of the doctor-patient relationship that has brought him this far is surely "the matrix, the indispensable condition," *Palko* v. *Connecticut*, 302 U.S. 319, 327 (1937), of any other freedom. For no other freedom is possible for a dying person — nothing remains that the dying person can call his own — if the State may prescribe the conditions under which, and the ways in which, the person may die. No liberty would truly belong to the dying individual if the process of dying were deemed a dance the State is free to choreograph, a final chapter the State is free to script.

All other persons, even the chronically ill and those who are not in the final stages of dying, may yet make many choices, select life paths, and explore possibilities that are beyond the State's authority and ability to control. Thwarted by the State in an attempt to commit suicide, they may yet live to rejoice that no "right to die" had been accorded them. A law preventing suicide in such cases cannot be said to reduce those denied such an option to "creature[s] of the state," *Pierce* v. *Society of Sisters*, 268 U.S. 510, 535 (1925), with every other liberty, and the very possibility of control over their lives, thereafter dependent on the State's sufferance.

Those who are suffering as they are about to die must be permitted this choice, not because their lives are worth less, Pet. Br. 20 & n. 10, but because — for their dignity, for their very humanity — the decision implies so much more. Indeed, respect for the precious quality of every human being requires that the Constitution be construed to protect the essential dignity of those for whom life is all but over equally with that of those with many years ahead.

This Court has already recognized just such a distinction in *Cruzan* v. *Director, Mo. Dept. of Health*, 497 U.S. 261 (1990), in considering the withdrawal of life-sustaining food and water. It is clear that the constitutional liberty recognized in that case extends *only* to "[a] seriously ill or dying" person. *Id.* at 288 (O'Connor, J., concurring); accord *id.* at 265 (opinion of the Court) (Nancy Cruzan

had "virtually no chance of recovering her cognitive faculties"). For at the same time that this Court recognized that the liberty of someone in Nancy Cruzan's condition includes the liberty to refuse life-sustaining food and water, see *supra* p. 2, the Court also made clear that the State is not "required to remain neutral in the face of an informed and voluntary decision *by a physically able* adult to starve to death." 497 U.S. at 280 (emphasis added).

That distinction is the very one we seek to reaffirm here — between what has traditionally been deemed "suicide" and a difficult, profoundly personal decision being made by a person who recognizes, no matter how much she desires to live, that all she has before her is the question of how to die.[8]

Because this Court has observed that "[s]ubstantive due process analysis must begin with a careful description of the asserted right," *Reno* v. *Flores*, 507 U.S. 292, 302 (1993) (internal quotation marks omitted), it is vital to stress that the only right asserted by the patient-plaintiffs and claimed before this Court is the right of the competent, terminally ill patient to choose whether to endure a death marked by intolerable agony, degradation, and suffering.[9]

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[8] As the Second Circuit suggested, see Pet. App. 34a, it will be for each State — and not this Court — at least in the first instance, to decide precisely when it regards this terminal phase of the dying process to have begun. As the Second Circuit found, the problem of definition, see Pet. Br. 21, is largely imaginary, because "most physicians would agree on the definition of 'terminally ill' . . . for purposes of the relief that plaintiffs seek." Pet. App. 34a; see *id.* ("it seems even more certain" that physicians "would agree on when" the "final stages" of dying begin); see Resp. Br. in *Glucksberg* 34-35. Further, the issue is one that New York law already faces: "Physicians are accustomed to advising patients and their families in this regard and frequently do so when decisions are to be made regarding the furnishing or withdrawal of life-support systems." Pet. App. 34a; see also N.Y. Public Health Law § 2961 (defining "terminal condition" for purposes of identifying the class of patients for whom surrogates may issue orders not to resuscitate).

[9] This is the appropriate level of generality at which the liberty in question should be described. As this Court has repeatedly held, "the liberty which encompasses [the Court's previous] decisions 'includes "the interest in independence in making certain kinds of important *decisions*."'" *Casey*, 505 U.S. at 859 (citations omitted and emphasis added). Thus, unlike petitioners themselves, the United States analyzes the respondents' claim at this level of generality (although in slightly different words), concluding that indeed there

A. This Court has Articulated a Principled Approach for Defining the Liberty Protected Under the Fourteenth Amendment

Casey includes a clear and principled articulation of the proper judicial approach to determining whether a government regulation implicates a constitutionally protected liberty. The Court explained that the judicial responsibility "to define the liberty of all," 505 U.S. at 850, calls upon the Court "not to mandate our own moral code," *id.*, but "to exercise that same capacity which by tradition courts always have exercised: reasoned judgment." *Id.* at 849. See also *Rochin* v. *California*, 342 U.S. 165, 171-172 (1952) (per Frankfurter, J.).

The Court adopted the approach advanced by the second Justice Harlan, under which the Court must define the scope of liberty by reference to the historically enduring principles (and not just the concrete historical practices) that are revealed in the decisions of this Court and the traditions of this Nation.

> [T]he full scope of the liberty guaranteed by the Due Process Clause . . . . is not a series of isolated points . . . . It is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints . . . . The best that can be said is that through the course of this Court's decisions [due process] has represented the balance which our Nation, built upon postulates of respect for the liberty of the individual, has struck between that liberty and the demands of organized society. . . . The balance of which I speak is the balance struck by this country, having regard to what history teaches are the traditions from which it developed as well as the traditions from which it broke. That tradition is a living thing. A decision of this Court which radically departs from it could not long survive, while a decision which builds on what has survived is likely to be sound.

Casey, 505 U.S. at 848-850 (quoting *Poe* v. *Ullman*, 367 U.S. 497, 543, 542 (1961) (Harlan, J., dissenting from dismissal on jurisdictional grounds)); see also *Griswold* v. *Connecticut*, 381 U.S. 479, 493-498 (1965) (Goldberg, J., concurring).

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is a protected liberty at stake here. See Govt. Br. in *Glucksberg* 12.

In upholding the woman's claim of liberty in *Casey*, the Court stated that "[i]t is settled now . . . that the Constitution places limits on a State's right to interfere with a person's most basic decisions about family and parenthood, as well as bodily integrity." 505 U.S. at 849 (citations omitted). After canvassing the precedents concerning marriage, procreation, contraception, the decision whether to bear or beget a child, family life and relationships, child rearing, and education, the Court concluded that such

> matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

Id. at 851.

The decision to end a pregnancy, the Court concluded, "originate[s] within the zone of conscience and belief." *Id.* at 852. Nonetheless, because the act of abortion is "fraught with consequences," *id.*, the Court inquired further into the nature of the liberty that the petitioners in that case sought to vindicate. The Court concluded that

> the liberty of the woman is at stake in a sense unique to the human condition . . . . The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear . . . . Her suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role, however dominant that vision has been in the course of our history and our culture. The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society.

Id. Consequently, the Court concluded in light of "the reasoning and the tradition of the precedents we have discussed" that the liberty of

the woman to choose to end a pregnancy was constitutionally protected. *Id.* at 853. This aspect of the *Casey* decision was not, as some have suggested, grounded upon *stare decisis*. "Even on the assumption that the central holding of *Roe* was in error, that error would go only to the strength of the state interest in fetal protection, not to the recognition afforded by the Constitution to the woman's liberty." *Id.* at 858; accord *id.* at 871.

B. A Principled Interpretation of the Constitution Requires Protection of the Liberty At Issue in This Case

The words from *Casey* about the profound, personal, even spiritual significance of the constitutionally protected decision at issue there apply with at least equal strength to dying people who must decide whether to endure a death marked by intolerable suffering. This Court has already concluded that "[t]he choice between life and death is a deeply personal decision of obvious and overwhelming finality." *Cruzan*, 497 U.S. at 281. Involving as it does profound questions of conscience and self-definition, the decision the patient-plaintiffs seek to make is unquestionably among "the most intimate and personal choices a person may make in a lifetime, [a] choic[e] central to dignity and autonomy." *Casey*, 505 U.S. at 851.

The right not to be forced to die in unendurable suffering and agony involves a constellation of interests — interests that have been recognized in this Court's previous cases — each one of which is, in and of itself, among the most profound that may be held by a human being and each of which is of constitutional dimension. To hold that the decision at issue in this case is less significant, or less firmly grounded in the Liberty Clause, than the decision whether to bear or beget a child, or to use contraceptives, or to send one's child to private school, would do irreparable damage to this Court's commitment to principled exposition of constitutional rights.[10]

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[10] Indeed, it would render this Court's decision in *Casey* itself vulnerable to repudiation as unprincipled and *ad hoc*, an illegitimate interference with the power of the State. Remarkably, some *amici* before this Court already argue that this Court should reverse in this case to make clear that *Casey* cannot "serve as . . . a precedent." See Br. of Sen. Orrin Hatch, *et al.* 22 (argument heading).

1. To begin with, of course, there is the interest in bodily integrity. Justice Cardozo's classic formulation comes from a New York State case: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . ." *Schloendorff v. Society of New York Hospital*, 105 N.E. 92 (N.Y. 1914). "It is settled now . . . that the Constitution places limits on a State's right to interfere with a person's most basic decisions about . . . bodily integrity." *Casey*, 505 U.S. at 849. See, *e.g.*, *Washington* v. *Harper*, 494 U.S. 210, 221-222 (1990); *Rochin* v. *California*, 342 U.S. 165, 172 (1952); *Cruzan* 497 U.S. at 288 (O'Connor, J., concurring).

This Court's cases make plain that this interest is not confined to avoiding forcible bodily intrusion but is equally implicated by a rule — such as that at issue in this case — prohibiting desired medical intervention. Indeed, as Justices O'Connor, Kennedy and Souter concluded in their opinion for the Court in *Casey*, the constitutional protection of the liberty of a woman seeking a doctor's assistance in terminating the natural progress of her pregnancy is, among other things, "a rule . . . of personal autonomy and bodily integrity." *Casey*, 505 U.S. at 857 (citing *inter alia Cruzan*, 497 U.S. at 278). Thus, this Court stuck down in that case a husband notification provision that might have prevented a woman from ending her pregnancy in part because "the State has touched not only upon the private sphere of the family but upon the very bodily integrity of the pregnant woman. Cf. *Cruzan* v. *Director, Mo. Dept. of Health*, 497 U.S. at 281." *Casey*, 505 U.S. at 896. Indeed, the very liberty to obtain medical treatment — a liberty surely protected under the Fourteenth Amendment, see Govt. Br. in *Glucksberg* 13 — implicates the interest in bodily integrity without involving any forcible bodily intrusion.

2. Next, the deeply personal interest in freedom from pain and suffering, even apart from the interest in personal autonomy, is implicated here as well. This, too, is unquestionably of constitutional dimension. In *Casey* this Court rested its conclusion about the woman's liberty partly on this very aspect of pregnancy: "The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear. . . . Her suffering is too intimate and personal," 505 U.S. at 852, for "the State to insist she make the sacrifice." *Id.*

One need not denigrate the pain and physical difficulty associated with childbirth or, indeed, the psychological pain and anguish associated with continuing an unwanted pregnancy, cf. Govt. Br. in *Glucksberg* 14, to recognize that the profound and unendurable suffering alleged by the plaintiffs here is no less than that associated with unwanted pregnancy, and that for the patients who seek the aid of this Court, it is all the more profound because it will last, without respite, until the short time left in their lives is over.[11]

3. Finally, the decision of one who is dying whether to endure an excruciating death involves, no less than the abortion decision, "the right to define one's own concept of existence, of meaning, of the universe, and" — most profoundly — "of the mystery of human life." 505 U.S. at 851. A decision about whether to die in such a way, or instead to take some action to hasten the end of suffering — be it withdrawal of food, or self-administration of some life-ending drug — is inevitably a reflection of a person's understanding of the meaning of life and of the role of death in that life. Undoubtedly it is true that "many religious and philosophical traditions hold that this suffering may be of great value." Truog, *et al.*, 327 New Eng. J. Med. at 1680. But "[b]eliefs about th[is] matter could not define the attributes of personhood were they formed under compulsion of the State." *Casey*, 505 U.S. at 851. This decision, like the decision whether or not to choose abortion, must "originate within the zone of conscience and belief." *Id.* at 852. It involves "[t]he destiny" of the patient, which "must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society." *Id.* Although, again as with abortion, the decision not to endure that suffering may be viewed by "some [as] nothing short of an act of violence against . . . human

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[11] Cf. Govt. Br. in *Glucksberg* 14-15 (arguing unconvincingly that the interest of a terminally ill patient in avoiding severe suffering is not as consequential as the interest in terminating a pregnancy). Nor need one denigrate the profound implications of the abortion right for women's equality — implications recognized in *Casey*, 505 U.S. at 856 — to recognize that, at least until now, laws prohibiting abortion have been invalidated by this Court only on Liberty Clause grounds, and that their invalidation on those grounds is appropriate. See Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to* Roe *v.* Wade, 63 N.C. L. Rev. 375, 382 (1985).

life," and although that pain might be "endured . . . with a pride that ennobles" the sufferer in the eyes of some, such "suffering is too intimate and personal for the State to insist, without more," *id.*, that an individual *must* bear it.

4. It is not our contention, as some of petitioners' *amici* suggest, that *Casey* has removed history and tradition from the due process equation. As the language from Justice Harlan quoted in *Casey* makes clear, 505 U.S. at 848-850, tradition is an important guidepost for judges bound to define the scope of the Liberty Clause of the Fourteenth Amendment. *Casey* recognized that constitutional significance inheres, however, not in the historic legality or illegality of a specific act, but in the treatment, in our history and tradition, of interests like those in bodily integrity and autonomy, in avoiding pain and suffering, and in making profoundly intimate and personal life-shaping decisions.

Concluding that the alternative would amount to nothing less than "shrink[ing] from the duties of our office," *id.* at 849, this Court, in "interpreting the full meaning" of the Constitution "in light of all our precedents," *id.* at 901, in *Casey* resoundingly rejected the view

> that the Due Process Clause protects only those practices, defined at the most specific level, that were protected against government interference by other rules of law when the Fourteenth Amendment was ratified.

Id. at 847 (citing *Michael H.* v. *Gerald D.*, 491 U.S. 110, 127-128 n. 6 (1989) (opinion of Scalia, J.)).

The Court observed that in many prior cases it had found practices protected under the Liberty Clause despite their having been unlawful in many states at the time of the ratification of the Fourteenth Amendment. *Id.* at 847-848. To the list given there can be added the right of a patient like Nancy Cruzan to refuse life-sustaining food and water. Thus, the fact that most states historically have forbidden physicians to provide life-ending medication to their suffering patients in the final stages of terminal illness does not alter the constitutional calculus in this case. Cf., *e.g.*, *Loving* v. *Virginia*, 388 U.S. 1, 12 (1967).

The protection of interests like bodily integrity and autonomy reflects "respect for the teachings of history . . . [and] the basic values that underlie our society." *Griswold*, 381 U.S. at 501

(Harlan, J., concurring). The Liberty Clause protects decisions where the underlying values at stake — not the particular practice at issue — are "deeply rooted in this Nation's history and tradition." *Moore* v. *City of East Cleveland*, 431 U.S. 494, 503 (1977) (plurality opinion of Powell, J.).

The Court in *Casey*, then, consistent with precedent, examined the "basic reasons why certain [actions] . . . have been accorded shelter under the Fourteenth Amendment," *id.* at 501, and concluded that those reasons required recognition of the liberty of a woman to choose whether or not to end a pregnancy. Those same reasons require recognition of the liberty asserted here.[12]

C. The *Cruzan* Decision, Too, Compels Recognition of the Patients' Fourteenth Amendment Liberty

The *Cruzan* Court's conclusion that Nancy Cruzan's constitutionally protected liberty to refuse "medical treatment" included the right to refuse artificial delivery of food and water, see *supra* p. 2, also requires recognition of the liberty at issue here.

1. In *Cruzan* this Court recognized that the right to refuse "medical treatment" included the right to refuse artificial delivery of food and water, "[w]hether or not the techniques used to pass food and water into the patient's alimentary tract are termed 'medical

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[12] The values at stake here are reflected in the sanctity with which the deathbed has always been surrounded in our history and tradition. An enormous solicitude for the rights of individuals as their lives draw to a close has marked our culture. Both the words and the wishes of one on his deathbed have traditionally and deservedly received legal protection. Thus, deathbed statements are generally admissible as evidence despite the hearsay rule, and the wishes of one facing imminent death are honored even when otherwise-required legal formalities are not met. See, *e.g.*, *Ridden v. Thrall*, 26 N.E. 627, 629 (N.Y. 1891) (gifts *causa mortis*). Even as death has, for most of us, changed its venue from the home to the hospital, there has been no concomitant change in our firmly-rooted tradition that holds death to be a personal and intimate event or in our belief that, to the extent possible, the dying person should be able to obtain that which will bring comfort. The very manner of dying — whether in solitude or surrounded by loved ones, with which family members to share one's final days and hours, from whom to seek solace and spiritual assistance — has always been recognized as a matter of profoundly personal choice.

treatment,'" 497 U.S. at 288 (O'Connor, J., concurring). This recognition undoubtedly was influenced by the profound indignity that would be wrought upon an unconscious patient by the slow atrophy and disintegration of her body that would accompany her continued life or what might more properly be called her "prolonged death." Cf. App. to Pet. for Cert. at A96, *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990) (No. 88-1503).

The importance to this case of *Cruzan*'s extension of the right to refuse medical treatment to include decisions to forego food and water cannot be overstated. The recognition of that right can only be understood as a recognition of the liberty, at least in some circumstances, to physician assistance in ending one's life. That was the very point of the Court's statement that "[t]he choice between life and death is a deeply personal decision of obvious and overwhelming finality." *Id.* at 281 (opinion of the Court).

Cruzan by its terms of course dealt with a physician's assistance in withdrawing nutrition and hydration, not with the provision of a life-ending prescription. But that cannot affect the nature of the *liberty* involved. Most important in *Casey* was this Court's recognition that the character and strength of an asserted liberty is the same whether the decision ultimately requires the state to respect the patient's wish to be free of medical intervention (as when a woman seeks to avoid a governmentally *coerced* abortion) or to respect the patient's wish to seek a physician's assistance in provision of a medical procedure (as when a woman seeks invalidation of a governmental *ban* on abortions). That was the point of the statement by Justices O'Connor, Kennedy and Souter, writing for the Court, that

> The soundness of [the liberty] prong of the *Roe* analysis is apparent from a consideration of the alternative. If indeed the woman's interest in deciding whether to bear or beget a child had not been recognized as in *Roe*, the State might as readily restrict a woman's right to choose to carry a pregnancy to term as to terminate it, to further asserted state interests in population control, or eugenics, for example. Yet *Roe* has been sensibly relied upon to counter any such suggestions.

Casey, 505 U.S. at 859 (citing cases involving forced abortion, coerced sterilization and the right to refuse life-sustaining treatment).

This quoted language from *Casey* also recognizes that the liberty to make protected decisions is a two-way street, so that it is inherent in a claim to such autonomy that a court cannot ask which way it will be exercised before concluding that liberty is indeed at stake. The *interests* asserted to overcome a claim of liberty will differ depending upon whether the State desires to prohibit its exercise in one or another direction (e.g., the interest in life vs. the interest in population control). And those interests may be of different strength, so that in theory one option might be permissible while another one is not. But those interests must be weighed against the protected liberty; they are not to be front-loaded into its definition.

Given this understanding of liberty, if the patient-plaintiffs here were to have no liberty to shorten their suffering, they would have no liberty to prolong it either. In an age of managed care, one can readily imagine a State deciding to prohibit extraordinary treatment for suffering patients who are about to die, on the ground that scarce resources would best be allocated elsewhere. See Pet. Br. 26 n. 15.

2. Further, this Court should recognize that advances in medical technology have all but swept away any line that once existed between the "artificial" life support that imprisoned Nancy Cruzan and the so-called "nature" that imprisons the patient-plaintiffs here. As Justice O'Connor put it in her opinion in *Cruzan*, "[a] seriously ill or dying patient whose wishes are not honored may feel a captive . . . . " *Id.* at 288 (O'Connor, J., concurring). Although the captivity she described there was the captivity "of the machinery required for life-sustaining measures or other medical interventions," *id.*, the idea of "captivity" applies with equal strength to those whose suffering takes place in lives not only prolonged but profoundly transformed — as so many now are (and as those of the named patient-plaintiffs here were) — by heroic or recently-unimaginable medical advances.

One may be alive only as a result of chemotherapy, antibiotics, bone-marrow transplants or any of the other wide range of life-prolonging therapies — each of which changes the patient unalterably, and ultimately may leave her "suffering" a "prolonged deat[h]" quite different from what "nature" would otherwise have decreed. See, *e.g.*, JA 126 (Declaration of Jack Froom, M.D.). When one then confronts, precisely because of that treatment, an end filled with life-encompassing pain, disintegration or suffering, how

can one *not* "feel a captive," *Cruzan*, 497 U.S. at 288 (O'Connor, J., concurring), to the very technology that has brought one to that point? To give but one of myriad examples, a patient who receives a bone marrow transplant may live longer than he otherwise would, but the very life-saving transplant may subsequently produce "graft versus host" disease in which the bone marrow graft actually attacks the rest of the host body and slowly kills it. For such persons, at the very least, there can be no doubt but that their liberty to choose death must be as great as Nancy Cruzan's.

3. There are also those terminally ill patients who receive ongoing palliative treatment that is itself profoundly painful, but without which their lives would be even more harrowing. Such treatments include, for example, daily infusion therapies, debriding dressing changes so painful they may require premedication with narcotics, and suction catheterization of the trachea to remove secretions. Ending such palliative — yet not life-sustaining — treatments would be unthinkable for these patients. They are thus left "captive of . . . medical interventions" just as Nancy Cruzan was, with "[s]uch forced treatment burdening [their] . . . liberty interests as much as any state coercion." *Id.*

4. The development of increasingly sophisticated life-prolonging techniques animates the entire question in the modern world of physician assistance in dying. See Preston, *Physician Involvement in Life-Ending Practices*, 18 Seattle L. Rev. 531, 542 (1995) ("Today, whether by intravenous feeding or by multiple-organ transplants, ... [m]ost persons in the late stages of dying are in their particular conditions exactly because of [past] medical intervention[s]."); Benrubi, *Euthanasia — The Need for Procedural Safeguards*, 326 New Eng. J. Med. 197-199 (1992) (describing life-prolonging treatments that result in prolonged suffering, and deaths "more protracted and uncomfortable" than the patient, even though not "on" life support, would have had otherwise). Changes in technology are likely to make whatever remains of the "natural"/"artificial" distinction grow even less meaningful in the future. This case thus requires the Court to apply the same principles that underlie *Cruzan* to factual circumstances vastly changed even from the time of the adoption of the very laws at issue in this case. Cf. *Ollman* v. *Evans*, 750 F.2d 970, 995 (D.C. Cir 1984) (en banc), cert. denied, 471 U.S. 1127 (1985) (Bork, J., joined by Wilkey, Ginsburg and MacKinnon, JJ., concurring) ("Where there

is a known principle to be explicated the evolution of doctrine is inevitable . . . In a case like this, it is the task of the judge in this generation to discern how the framers' values, defined in the context of the world they knew, apply to the world we know.").

Due Process would not, in the 18th through mid-19th centuries, likely have been thought to include the right to avoid the artificial prolongation of life. But medical science was primitive. Cf. Maurice B. Gordon, *Aesculapius Comes to the Colonies* 5 (1949). It has been only this century that ushered in the life-extending medical techniques that may, for all their benefit, also lead to more grotesque forms of death, and with them the recognition of the constitutional significance of avoiding an artificially-prolonged life. See *Cruzan*.

As their declarations make clear, each of the patient-plaintiffs in this case was — thankfully — kept alive by extraordinary medical advances, only to face a lingering death instead of what might have been a swift one. In defining the scope of their liberty in this case in light of that modern reality, this Court must take account of the factual circumstances in which its decision will apply. It must issue a decision that is "defensible . . . as [an] applicatio[n] of constitutional principle to facts as they ha[ve] not been seen by this Court before." *Casey*, 505 U.S. at 863-864. Indeed, a proper understanding of these "significant facts," *id.* at 866, is essential to the very performance of the judicial function in this case.

D. Recognition of the Liberty Involved Here Does Not Require Taking the Approach That Led to Much of the Criticism of *Roe* v. *Wade*

A judgment of affirmance here can and should be rendered in a way that avoids the pitfalls that led to much of the scholarly criticism of the decision in *Roe* v. *Wade*, 410 U.S. 113 (1973). *Roe* almost completely foreclosed the States from legislating in the area of abortion, in an opinion that "'rea[d] like a set of hospital rules and regulations.'" Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to* Roe *v.* Wade, 63 N.C. L. Rev. 375, 381 (1985) (brackets added) (quoting Archibald Cox, *The Role of the Supreme Court in American Government* 113 (1976)). Commentators have urged that "[t]he Court properly invalidated the

Texas proscription" at issue in *Roe* "because '[a] law that absolutely made criminal all kinds and forms of abortion . . . is not a reasonable accommodation of interests,'" *id.* at 382 (quoting Freund, *Storms Over the Supreme Court*, 69 A.B.A. J. 1474, 1480 (1983)), but that "[i]f *Roe* had left off at that point and not adopted . . . a 'medical approach,'" the decision would have been understood more widely as an appropriate judicial act. *Id.*

Because New York's criminal law is so extreme, this case presents an opportunity appropriately to vindicate individual liberty while avoiding these pitfalls. The controlling opinion in *Casey* abandoned *Roe*'s "elaborate but rigid," 505 U.S. at 872, framework in favor of the "undue burden" standard under which this Court would be able to invalidate the complete criminal prohibition at issue here while permitting a substantial degree of less intrusive regulation. This standard promises the "reasonable accommodation of interests" that critics of the *Roe* opinion have argued is appropriate.

II. ALTHOUGH THIS LIBERTY CAN BE CLOSELY REGULATED, THE STATE'S ABSOLUTE BAN IMPOSES AN UNDUE BURDEN ON ITS EXERCISE

Recognition of a protected liberty is of course only the first half of the due process equation. Before determining that a law or regulation is unconstitutional, a court must weigh the countervailing state interests urged in its support to see if they may justify the particular interference with protected liberty. See, *e.g.*, *Cruzan*, 497 U.S. at 279. The question of whether laws touching upon the liberty at stake in this case should be measured under the undue burden standard adopted by the controlling opinion in *Casey*, 505 U.S. at 876 (plurality opinion), or under the test which asks whether a regulation is "narrowly tailored to serve a compelling state interest," e.g., *Reno* v. *Flores*, 507 U.S. 292, 302 (1993), is one this Court need not resolve here, for the blanket prohibition at issue in this case cannot survive under either standard.

The United States, acknowledging the liberty at stake here, argues that the Court should apply "the same legal standard" it applied in *Cruzan*. Govt. Br. in *Glucksberg* 17. But *Cruzan* itself did not explicitly apply *any* particular standard of review, holding only that the procedural requirements put in place in that case by Missouri law

"permissibly . . . advance [the State's] interests." 497 U.S. at 282.[13] This Court, however, has subsequently made clear that *Cruzan* necessarily stands for the proposition that "a State's interest in the protection of life falls short of justifying any plenary override of individual liberty claims." See *Casey*, 505 U.S. at 857 (citing *Cruzan*, 497 U.S. at 278). This is consistent with the undue burden standard articulated in *Casey*, a standard whose application suffices to support affirmance here.

Indeed, application of the undue burden standard may be particularly appropriate in this case, for it was designed to accommodate important state interests when an individual seeks to make a constitutionally protected choice, like the one involved in this case, "that has such profound and lasting meaning." *Casey*, 505 U.S. at 873 (plurality opinion).

The joint opinion in *Casey* articulated "[s]ome guiding principles" for application of the undue burden test, which it described as "a standard of general application." See 505 U.S. at 877, 876 (plurality opinion); see also *id.* at 878. Under this test, regulations touching on a protected liberty will be upheld only if they are "reasonably related," *id.*, or "'reasonably directed,'" *id.* at 900, to an "'important and legitimate,'" *id.* at 871, or "substantial," *id.* at 876, governmental interest. Further, no regulation will be permitted "that has the purpose or effect of placing a substantial obstacle in the path" of an individual seeking to exercise a constitutionally protected liberty. *Casey*, 505 U.S. at 877 (plurality opinion); see also *id.* at 878 (illustrating that even a properly tailored regulation will be struck down if it has this purpose or effect). In determining whether it poses a "substantial obstacle," a law that touches on constitutionally protected liberty is to be measured by reference to "those for whom it is an actual rather than an irrelevant restriction." See *id.* at 895;

[13] The United States describes *Cruzan* as applying "an intermediate standard . . . in which the individual's 'liberty interests' are 'balance[d] • • • against the relevant state interests.'" Govt. Br. in *Glucksberg* 17 (quoting *Cruzan*, 497 U.S. at 279). The quoted language from *Cruzan*, however, does not articulate a legal standard. An examination of the quoted passage reveals that it merely describes the process by which a court — under whatever standard — must evaluate a claim that a law or regulation unlawfully infringes upon a constitutionally protected liberty.

see also *Fargo Women's Health Organization* v. *Schafer*, 507 U.S. 1013, 1014 (1993) (O'Connor, J., joined by Souter, J., concurring in denial of application for stay and injunction).

States are permitted under the undue burden test to enact laws that "create a structural mechanism by which the State, or [an interested individual], may express profound respect for . . . life . . . , *if they are not a substantial obstacle*" to the person's "exercise of the right to choose." *Id.* at 877 (emphasis added). This may include regulations that "provide a reasonable framework" for ensuring that the liberty is not exercised incautiously, *id.* at 885-887, as well as regulations designed to persuade the individual to choose life. See *id.* at 872-873. The test recognizes that "[w]hat is at stake is the [person's] right to make the ultimate decision, not a right to be insulated from all others in doing so." *Id.* at 877.

A. The Legitimate Interests Put Forward by Petitioners Cannot Justify The Challenged Laws

None of the interests put forth by petitioners suffices to justify New York's legal regime.

1. Petitioners begin with the State's interest in protecting life in all circumstances. See Pet. Br. 20-21. Accepting that interest as legitimate, the criminal laws at issue here sweep much too broadly, placing a substantial (indeed, a virtually insurmountable) obstacle in the path of those in the final stages of terminal illness who are not on life-support and who seek to exercise their protected liberty to choose a death free of unbearable pain and suffering. See Resp. Br. in *Glucksberg* 27. Such a "plenary override of individual liberty claims" like these has been held impermissible. See *Casey*, 505 U.S. at 857 (citing *Cruzan*, 497 U.S. at 278).

The argument that the ban is essential to meet the State's interest in protecting life in all circumstances is also fatally undermined by the fact that the State has chosen to authorize much requested physician action intended to result in the death of a competent terminally ill adult. Cf. *City of Ladue* v. *Gilleo*, 114 S.Ct. 2038, 2044 (1994) (exemptions from a ban, there on displaying signs, "diminish the credibility of the government's rationale" for imposing the restriction in the first place). It permits, virtually without regulation, the life-ending withdrawal of treatment, including

nutrition and hydration, and it allows terminal sedation of those who are not already on life-support. New York's legal regime thus would not be a reasonable means of advancing the State's interest in life even if it did not present a substantial obstacle to the exercise of protected liberty. See *e.g.*, *Clark* v. *Jeter*, 486 U.S. 456, 464 (1988) (six-year statute of limitations for child support actions involving illegitimate children not "substantially related" to Pennsylvania's interest in avoiding litigation of stale or fraudulent claims because "[i]n a number of circumstances [the State] permits the issue of paternity to be litigated more than six years after the birth of an illegitimate child").

Petitioners argue that what is permitted in terms of withdrawal of life-sustaining treatment "may be distinguished" from what is forbidden "on the basis of [the] intention of both physician and patient." Pet. Br. 15. But, as we have seen, the law of New York does not actually hew to this line, instead permitting withdrawal of treatment even where the actual intention of both doctor and patient plainly is to cause death. Ultimately, petitioners acknowledge as much, arguing only that the purpose of one who seeks withdrawal of treatment "*may* be not death but, for example, the avoidance of invasive medical technology." Pet. Br. 16.

Petitioners also argue that their decision to permit withdrawal of life-sustaining treatment is justified by a difference in the cause of death: "[a] patient who declines or withdraws from life-sustaining treatment is letting nature take its course," Pet. Br. 17, whereas one who is not on artificial life support dies "from the drugs alone." *Id.* 18.[14] But even putting to one side the manifestly *un*natural case of terminal sedation, the law of New York recognizes that withdrawal of life support is ordinarily a but-for cause of the death that inevitably ensues. It punishes unconsented withdrawal of life-sustaining treatment as homicide. And even the consensual withdrawal of life-sustaining treatment for the purpose of causing the death of one who is not terminally ill may sometimes be treated as

[14] In truth, of course, since withdrawal of a life-support system such as a respirator is invariably accompanied by pain medication, "it is not possible to know if the morphine or the disease produced the actual moment of death." Br. of Choice in Dying 11.

unlawful assisted suicide. See *Fosmire* v. *Nicoleau*, 551 N.E. 2d 77, 82 & n. 2 (N.Y. 1990); *Van Holden* v. *Chapman*, 450 N.Y.S. 2d 623, 625, 626-627 (App. Div. 1982). Thus, New York law does not simply permit nature to "take its course."[15]

Finally, the AMA argues that the State must permit withdrawal of life-sustaining treatment (but not the provision of life-ending medication) because patients would be reluctant without that option to accept many modern treatment regimens. AMA Br. 23. Yet this cannot explain the line drawn by the State, because many life-prolonging treatments that do not involve permanent attachment to life-sustaining equipment — from antibiotics to chemotherapy to surgery — leave patients at a profound risk of debilitation or pain. If the option of withdrawing life-sustaining devices is necessary to encourage people to seek therapies that require such devices, then the option of life-ending medication should be equally necessary to encourage people to obtain this latter class of life-prolonging treatment.

2. Next the State and its *amici* proffer a series of interests related to the protection of those who are "outside the class of persons described by the Court of Appeals": those for whom palliative care or treatment of depression might ease suffering, those for whom exercise of the liberty might not truly be voluntary, and those who are not actually in the final stages of terminal illness. See Govt. Br. in *Glucksberg* 23. These reflect serious concerns about avoiding abuse and the mistaken exercise of this life-ending liberty. See Pet. Br. 27; Govt. Br. in *Glucksberg* 19-24 (detailing ways in which the decision to end life may be mistaken or may be the result of pressures felt from physicians and family).

Undoubtedly the protection of people who might seek to end life mistakenly or under pressure is a compelling interest. This interest, however, does not require a complete ban on the provision of life-

[15] Petitioners also argue that the interest in protecting life does not require prohibiting withdrawal of life-sustaining treatment when intended to cause death because of the "difference between action and inaction." Pet. Br. 16-17. The State's homicide laws of course answer this, recognizing that the removal of, say, a feeding tube does not amount to "passive inaction," *id.* at 17 (internal quotation marks and citations omitted). Indeed, if anything, death from a drug that is self-administered involves *less* action on the part of the physician.

ending medication even to those for whom the right to self-administer such a prescription drug is a protected liberty, and who act without pressure or error. There are a number of less restrictive mechanisms that the State could mandate that would reasonably advance — would in fact be precisely tailored to address — the interests petitioners and their *amici* put forth. See Br. of State Legislators in Support of Respondents 23-25, 29, App. 1a-12a. Indeed, in permitting the issuance of orders not to resuscitate — which implicate many of these same concerns — New York has already put some such regulations in place. See N.Y. Public Health Law § 2964.[16]

In light of such alternatives, the ban at issue in this case, even if it did not strike impermissibly to the bone of protected liberty, could not be said "reasonably" to advance the State's interest in avoiding mistake or coercion. Indeed, at least unless it is absolutely necessary, the imposition of intolerable suffering upon a human being is not a constitutionally permissible means of achieving these or the other goals put forward as justifications for the law at issue here, such as creating an incentive for improving the medical profession's attention to patients' pain, see AMA Br. 22, or "increas[ing] the public's awareness of hospice" care. National Hospice Association Br. 18. Cf. *Eisenstadt* v. *Baird*, 405 U.S. 438, 448 (1972).

Furthermore, any argument that this ban has been put in place as a necessary mechanism to prevent mistakes, coercion or, indeed, even involuntary euthanasia, dissolves in the face of the fact that some patients already intending to die may lawfully receive, essentially without any regulatory safeguards at all, physician assistance in dying through the withdrawal of life-sustaining treatment (or through the process of terminal sedation).[17] The

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[16] That *any* regulatory scheme might occasionally be evaded by the physicians subject to it, Pet. Br. 31, proves too much: the "outright prohibition" defended as an alternative to targeted safeguards, AMA Br. 23, has already proven susceptible to circumvention, and may indeed invite a cynicism that makes evasion even more tempting. See *infra* at p. 40-42.

[17] Coercion and undue influence in this setting might be addressed by the criminal prohibition against "caus[ing] . . . suicide," *e.g.*, N.Y. Penal Law § 125.15(3), which is not challenged in this action. And indeed, because that

precise risks about which the State claims to be concerned are of course equally present in those circumstances. Indeed, many of them (such as family coercion or a failure of physician sensitivity) might well be *more* salient in the case of a person connected to life-sustaining medical equipment. And, because disconnecting life-support machinery typically gives the patient no last clear chance at a change of heart — it is the doctor's hand, not the patient's, that takes the final step[18] — there is, if anything, *less* basis for confidence that the process causing the patient's death is in fact a genuine expression of the patient's free and informed will rather than the instrument of a homicide.[19]

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statutory provision could be applied to those who pressure patients to request or use life-ending medication as well, there should be no concern that affirmance in this case will create a regulatory vacuum until the state legislature can revisit the matter. Further, the laws here are challenged not on their face but only as applied to the class of terminally ill, competent persons who voluntarily choose to obtain a prescription for life-ending medication. New York's Attorney General would be free to enforce the state's assisted suicide laws with respect to all others and indeed would be free immediately to adopt interim guidelines to ensure that only competent persons in the final stages of terminal illness avail themselves of the relief sought here and that all decisions concerning life-ending medication are fully voluntary.

[18] Indeed, in one major study, 39% of the patients who asked for and received lethal medication (despite the formal illegality) did not use it once their sense of control was re-established. Back *et al.*, *Physician Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 922 (1996); see also Richard Posner, *Age and Old Age* 224 (1995) (predicting that permitting physicians to prescribe life-ending medication "might actually reduce the number of suicides and postpone the suicides that do occur").

[19] The suggestion by the United States that withdrawal of life-sustaining treatment may be distinguished from the provision of life-ending drugs on the ground that withdrawal may reveal that a person has been misdiagnosed, see Govt. Br. in *Glucksberg* 25 — something that typically would not happen with a prescription of life-ending medication — is wrong. Patients like Nancy Cruzan will invariably die quite quickly if their life-support is withdrawn, regardless of the accuracy of their physicians' diagnosis that there is no hope of recovery. (Thus, as biology dictates, Karen Ann Quinlan, who was ultimately able to breathe on her own, lived for years after withdrawal of her respirator, see Govt. Br. 14, only because artificial nutrition and hydration were provided.) That certainty of death is precisely why this Court in *Cruzan* concluded that it was permissible to place the risk of error on the party seeking

In any event, this Court has never permitted a State completely to deprive some persons of a constitutionally protected liberty in order to protect "*other* persons," Govt. Br. in *Glucksberg* 19 n. 2 (emphasis added), from its own failure to put in place mechanisms to ensure that this liberty is exercised only by those entitled to do so. See, *e.g.*, *Sable Communications* v. *FCC*, 492 U.S. 115, 128 (1989) (even to protect children, government may not "reduce the adult population . . . to . . . only what is fit for children") (ellipsis in original, internal quotation marks and citations omitted).

3. Petitioners and their *amici* also argue that the liberty at stake here is outweighed by the countervailing interest in preventing such consequences as non-voluntary euthanasia and euthanasia under a "best interests" standard for incompetent patients. Pet. Br. 23-24.

Cruzan itself provides the strongest response. The Court there held it permissible for a state to "seek to safeguard the personal element" of the "choice between life and death" "through the imposition of heightened evidentiary requirements" whenever it allows a surrogate to exercise the rights of an incompetent patient. 497 U.S. at 281; see also *id.* at 289-292 (O'Connor, J., concurring).[20]

In any event, the "slippery slope" claim here rings particularly hollow in light of the types of life-ending measures the State already permits physicians to undertake. If there is a slope to fear, the State — in permitting withdrawal of life-support, death by "double-effect" and terminal sedation, all essentially without regulation — has already slid along it further than anything respondents seek.

In particular, under the guise of "double effect," acts of euthanasia take place in New York and throughout the United States *every day*. See, e.g., Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 New Eng. J. Med. 1374, 1376 (1996). Dying

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to terminate life-support. See *Cruzan*, 497 U.S. at 283.

[20] Petitioners raise concerns about suffering, terminally-ill patients who are unable to administer drugs to themselves. Pet. Br. 23. But any competent individual, however disabled, who is able with the assistance of modern technology unambiguously to *communicate* a voluntary decision to receive life-ending medication could certainly be enabled, through modern technology, to *self-administer* it.

patients in agony, whose pain cannot be soothed with medication, are given increasingly large doses of painkillers that will undoubtedly kill them. E.g., Cotton, *Medicine's Position is Both Pivotal and Precarious in Assisted Suicide Debate*, 273 JAMA 363 (1995). But because states like New York make it hazardous for the foreseeable, natural consequence of this medication to be confronted frankly, the drugs are administered — by doctors undoubtedly acting in what they believe to be the best interests of their patients — without the full discussion of the consequences to which respect for a patient's very humanity entitles her. *Id.* ("We talk about the 'double effect,' and know jolly well we are sedating them into oblivion, providing pain relief but also providing permanent relief, and we don't tell them.") (quoting Dr. Peter Goodwin); see Br. of Coalition of Hospice Professionals for Affirmance 26.[21] In this

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[21] Petitioners' claims about the Netherlands, see Pet. Br. 24 n.13, are conspicuously bereft of any evidence at all that Holland's decision to permit physician assistance in dying (while still deeming it technically criminal) actually led to any *increase* in involuntary euthanasia by doctors rather than simply bringing to light "a practice that, in the Netherlands as in every other country (including the United States), has been going on undercover and entirely at the discretion of the physician." Margaret Battin, *The Least Worst Death* 141 (1994). The most recent report on the subject concludes that the data of the well-known 1991 study of the Dutch experience, and of its 1996 successor, "do not support the idea that physicians in the Netherlands are moving down a slippery slope" towards "less careful end-of-life decision making and . . . the gradual social acceptance of euthanasia performed for morally unacceptable reasons." van der Maas *et al.*, *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands*, 1990-1995, 335 New Eng. J. Med. 1699, 1705 (1996).

To the extent that any conclusions can be drawn, it appears that a system of genuine regulation might actually lead to a *decrease* in the rate of nonvoluntary euthanasia. Although there are no strictly comparable data, studies suggest that there may be more such euthanasia in the United States than in Holland. For example, seven percent of surveyed U.S. critical care nurses had "engag[ed] in euthanasia or assisted suicide without a request from either the patient or a surrogate." See Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 New Eng. J. Med. 1374, 1376 (1996). The article reporting that data appears to suggest that some of the patients killed in this way were mentally competent. *Id.*

The precisely comparable figures for the Netherlands are difficult to determine, since in the Dutch studies "nonvoluntary" euthanasia has been

regard, a decision of this Court upholding the right of patients to discuss and receive life-ending medication openly — a decision that will doubtless lead to regulation of these life and death decisions — may actually play a critical role in pulling this nation *back* from the precipice of involuntary euthanasia.[22]

B. The Only Rationales That Adequately Explain New York Law are Impermissible Bases for Imposing Such Suffering on the Dying Patient

Implicitly acknowledging that the State permits, in the case of withdrawal of life-sustaining treatment, precisely the acts that it would deem "assisted suicide" were they to involve the provision of life-ending prescription drugs, the United States attempts to defend the State's regime on the ground that "[i]n one case, the cause of death *can reasonably be viewed* as the underlying disease;" in the other, "the cause of death can only be *viewed* as the lethal medication." Govt. Br. in *Glucksberg* 24 (emphasis added). The United States argues that permitting the more obvious type of physician assistance "'[c]ould have a subtle but widespread impact on society' by sending the message that society does not value each of its members." Govt. Br. 12 (citation omitted). In essence,

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defined to include all deaths caused intentionally but without a "concurrent, explicit" request by the patient. But the latest Dutch report suggests that in *every* case involving a competent patient whose death was counted within this category (many of whom had only hours or days to live), "either the decision was discussed with the patient earlier in the illness or the patient had expressed a wish for euthanasia if suffering became unbearable." See van der Maas, *et al.*, 335 New Eng. J. Med. at 1701.

[22] Petitioners contend that the liberty urged here will require patients constantly to justify their decision to remain alive. Pet. Br. 32. The fatal problem with this argument is that it could be used to object to any constitutionally protected liberty, from the right to free speech to the right to choose abortion. A State's desire to protect its citizens from the "burden" of liberty is obviously illegitimate. In any event, terminally ill patients on life support already must confront this choice under New York law. As the Second Circuit found, just as much "'psychological pressure' can be applied" upon "the elderly and infirm to consent to withdrawal of life-sustaining equipment as to take drugs to hasten death. . . . [T]he state of New York may establish rules and procedures to assure that all choices are free of such pressures." Pet. App. 32a-33a.

therefore, this final argument for reversing the decision below amounts to a claim that, whatever constitutional rights dying individuals might have to avoid the agony or indignity to which some are condemned by the state laws now in place, those rights are best sacrificed in the larger interest of preserving appearances.

But surely the Constitution does not permit the State to sacrifice the rights of the dying on the altar of appearances. However well-tailored the State's ban is to the achievement of this goal, it cannot be doubted, in a nation committed not to regulation by winks and nods but to the rule of law — indeed in a nation committed to the democratic accountability of its governmental officials, see *New York* v. *United States*, 505 U.S. 144, 182-183 (1992) — that a state's interest in *appearing* to protect life in a way that it does not actually protect it is neither sufficiently "substantial" nor sufficiently "important" to outweigh a terminal patient's liberty to avoid a horrific death. Indeed, there is no more fixed constitutional principle than that the government has *no* interest in restricting the awareness of its citizenry. See, *e.g.*, *44 Liquormart, Inc.* v. *Rhode Island*, 116 S.Ct. 1495, 1508 (1996) (Stevens, J., joined by Kennedy and Ginsburg, JJ.); *id.* at 1515-1520 (Thomas, J., concurring in part and concurring in the judgment).[23]

This Court is also urged not to recognize a right to end suffering, essentially because it would result in regulation of *all* the death-causing medical treatment in which the State now permits physicians to engage. The AMA argues that "the unprecedented intrusion into the physician-patient relationship needed independently to regulate such treatment decisions would" be "all too likely to undermine what progress has been made in decisions to withdraw or withhold life-sustaining treatment and to use effective pain control," AMA Br. 17; see also *id.* at 22 (if the "boundary is lost, much support for . . . withdrawing treatment . . . may be lost as well").

But the State can have no legitimate interest in protecting doctors

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[23] There is of course all the difference in the world between ending practices that lead to a profession's bad reputation, see *Florida Bar* v. *Went For It, Inc.*, 115 S.Ct. 2371, 2376 (1995), and employing the law to *cover up* existing practices that one fears may have that same effect — a choice that no view of the First Amendment could sanction.

from what all must concede to be not only appropriate but necessary regulation. The interest in physician freedom cannot justify the indignity and brutality of the way the State insists that those with intractable end-of-life pain and distress must be prepared to die.

III. THE LINES DRAWN BY THE STATE OF NEW YORK ARE ARBITRARY AND IRRATIONAL AND SO VIOLATE THE EQUAL PROTECTION CLAUSE

Even if this Court were to conclude that there is no protected liberty here — or were it to desire not to reach that constitutional issue — the judgment below should still be affirmed, because the distinctions drawn by New York law are irrational, and so violate equal protection even under the scrutiny applicable when no independently protected liberty is involved.[24]

"In applying the Equal Protection Clause to most forms of state action, we . . . seek only the assurance that the classification at issue bears some fair relationship to a legitimate public purpose." *Plyler* v. *Doe*, 457 U.S. 202, 216 (1982). But although "[a] legislature must have substantial latitude to establish classifications" that "accommodate competing concerns both public and private, and that account for limitations on the practical ability of the State to remedy every ill," *id.*, a distinction drawn in the law "must be reasonable, not arbitrary, and must rest upon some ground of difference having a fair and substantial relation to the object of the legislation." See *Eisenstadt*, 405 U.S. at 447 and n. 7 (quoting *Reed* v. *Reed*, 404 U.S. 71, 75-76 (1971) (internal quotation marks and citation omitted)).

As this Court's precedents make clear, this standard, though deferential, does not amount to judicial abdication. Applying it, this Court has never shied away in appropriate circumstances from

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[24] Of course, if this Court concludes that the laws at issue in this case intrude on a constitutionally protected liberty — or that the political process is systemically incapable of adequately protecting the interests of the dying, see Resp. Br. in *Glucksberg* 39 n. 26 — those laws would violate equal protection because, as shown above, see *supra* pp. 35-43, the State has failed to show that the distinctions drawn by its laws are narrowly tailored to serve a compelling state interest.

invalidating arbitrary classifications and legislation. See, *e.g.*, *Romer* v. *Evans*, 116 S.Ct. 1620, 1627-1629 (1996); *Allegheny Pittsburgh Coal Co.* v. *County Commission of Webster County*, 488 U.S. 336, 344-346 (1989); *City of Cleburne* v. *Cleburne Living Center*, 473 U.S. 432, 447-450 (1985); *Hooper* v. *Bernalillo County Assessor*, 472 U.S. 612, 619-623 (1985); *Eisenstadt*, 405 U.S. at 447-455; *Reed*, 404 U.S. at 75-77.

A. The Distinction Between Withdrawal of Life-Sustaining Treatment and the Provision of Life-Ending Medication, As Drawn By New York Law in the Context of Intentionally Death-Causing Behavior, is Not Rational

Even assuming the State had asserted a legitimate interest in compelling a dying patient to keep suffering against her will, the principal line drawn by state law is both arbitrary and irrational. The State purports to prohibit doctors from assisting their patients to die with dignity when they are in the final stages of terminal disease and are intolerably suffering. Thus a doctor may not assist such a patient by providing life-ending medication for her own administration even when, in the physician's professional opinion, it is medically and psychiatrically appropriate. Yet the State permits doctors deliberately to assist such patients to die if they can do so by withdrawing life-sustaining treatment, including artificially provided food and water.

The decision in this context to distinguish those who are on life-sustaining treatment from those who are not simply cannot be justified. The State treats them differently "on the basis of criteria wholly unrelated to the objectives of th[e] statute[s]" at issue. *Reed* v. *Reed*, 404 U.S. at 76. As applied to acts equally intended to facilitate death, the line cannot be defended on the ground of a difference of intent. See Pet. Br. 15-16. For, as described above, although the State refuses to *characterize* the intent of the patient in the former case as an intent to die, the legal distinction does not depend on any difference in *actual* intent between the patients the doctors are permitted to assist to die and those whom they are not. See *Colorado Republican Campaign Committee* v. *F.E.C.*, 116 S.Ct. 2309, 2319 (1996) (Breyer, J., joined by O'Connor and Souter, JJ.) (the government's "characterization" of its actions cannot control

"for constitutional purposes"); *id.* at 2321-2322 (Kennedy, J., joined by Rehnquist, C.J., and Scalia, J., concurring in the judgment and dissenting in part) ("[W]e cannot allow the Government's suggested labels to control our [constitutional] analysis.").

Nor can a distinction in "causation" between "natural" death and death by human "intervention" justify the line drawn by the State. Pet. Br. 17-18. Petitioners argue that one who is disconnected from life-sustaining treatment "is letting nature take its course" in that "[h]is death is caused by the underlying disease or disorder." *Id.* But this Court has recognized that is not the case. See *Cruzan*, 497 U.S. at 280 (referring to "hav[ing] hydration and nutrition withdrawn in such a way as to cause death"). And even New York law does not pretend it is true: Any doctor who disconnected a person from life-support *without* informed consent could be prosecuted for committing homicide by "causing" the patient's death; and any doctor who disconnected from life-support a patient who requested such action in order to die but was otherwise likely to recover could be prosecuted for assisting a suicide. Moreover, as the court below observed,

> there is nothing "natural" about causing death by means other than the original illness or its complications. The withdrawal of nutrition brings on death by starvation, the withdrawal of hydration brings on death by dehydration, and the withdrawal of ventilation brings about respiratory failure. . . . It certainly cannot be said that the death that immediately ensues is the natural result of the progression of the disease or condition from which the patient suffers.

Pet. App. 30a. See also *Cruzan*, 497 U.S. at 296-297 (Scalia, J., concurring).

Nor can the line drawn by New York be defended on the basis that those individuals whom the State permits to obtain a physician's help in dying, and only those individuals, are "being subjected to an ongoing bodily intrusion" and, "just as they could have refused the intrusion, they can withdraw their consent at any time," so that it is neither their "terminal illness" nor any positive action or decision of the State but simply "the now undesired bodily intrusion" that "empowers" them to end their lives by "refus[ing] further treatment" and having life-support removed. Br. for Bioethics Professors

Supporting Petrs. 14.

A desire to permit patients to effect the termination of bodily intrusions simply cannot justify the line drawn by the State. First, as we have seen, see *supra* pp.10-11, the State does not *always* permit the life-ending withdrawal of treatment by non-terminal patients whose intent is to die. Second, patients currently "on" life-support and those who are not both may have had bodily intrusions which are ongoing and for which they have given consent: an artificial heart valve, a kidney or a bone marrow transplant, for example. These are considerable bodily invasions that change the patient inalterably, and may transform the nature of her death.

Such patients may wish to die by withdrawing their consent to the bodily intrusion to which they have been subjected. But their cases demonstrate that the State's line is not about permitting patients to undo a battery. Even where withdrawal of consent is theoretically possible, the State would doubtless say that a patient has no right to end his own life by insisting, for example, that surgeons remove a donor kidney or heart that had already been implanted. On the other hand, if the State *did* permit this type of life-ending physician assistance, how could it argue that it is rational not to permit the same patient to obtain a lethal dose of medication from a physician for the same ultimate purpose?

Nor, finally, can the line be defended on the basis of a difference — whether in kind or degree — in the risks involved. As we have shown, all the risks of error and coercion are at least as great with respect to what the State permits as to what it forbids. See *supra* pp. 38-39. Likewise, the argument from medical necessity — that patients will not endure technologically-advanced treatments without the option of voluntarily seeking physician assistance in dying — applies with the same force on both sides of the state-drawn line. See *supra* p. 37.

Indeed, the very way the line developed underlines the impossibility of defending it. The statutes at issue in this case admit by their terms of no exceptions for those receiving life-sustaining treatment. Those exceptions are part of the gloss put on the statutes by a series of decisions of the New York courts. Because the resulting legal regime is thus not a reflection of any coherent legislative judgment — because it does not "establish classifications that accommodate competing concerns both public and private,"

Plyler v. *Doe*, 457 U.S. at 216 — it is hardly surprising that petitioners' *post hoc* rationalizations of the lines drawn by the State fall so far short of the mark. Cf., e.g., *United States* v. *Virginia* 116 S.Ct. 2264, 2275 (1996) (rationales offered only in hindsight not credited). Yet the fact that the line at issue here may in this sense be explicable as an historical vestige cannot itself save it. For even when the historical record can *explain* an anomaly, "an explanation is not the same as a justification." *Norman* v. *Reed*, 502 U.S. 279, 294 n. 10 (1992). See also, *e.g.*, *Allegheny Pittsburgh Coal Co.*, 488 U.S. at 344-346 & n. 4 (when a policy that might be sound in the abstract is applied in an "aberrational" way that creates an irrational disparity, it violates equal protection); accord *Nordlinger* v. *Hahn*, 505 U.S. 1, 15 (1992) (upholding similar scheme that was intentionally adopted).[25]

B. The Distinction Between Terminal Sedation and Prescription of Life-Ending Medication is Not Rational

If any doubt were to remain as to the irrationality of the line New

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[25] The United States attempts to establish that New York's legislature has deliberately chosen to "preserve the distinction" between "refusing unwanted medical treatment" and "assisted suicide." Govt. Br. 16-17. The events to which it points do not support this contention. There is no evidence that the failure in 1965 to *delete* the assisted suicide laws was a reflection of any conscious thought whatever. Pet. App. 41a n. 6. The 1987 Orders Not to Resuscitate Act has nothing to do with the distinction to which the United States refers. Finally, the 1990 Health Care Agents and Proxies Act actually acknowledges the judicial decisions permitting the life-ending withdrawal or withholding of artificially-supplied food and water, explicitly permitting health-care agents to decide about this, provided the wishes of the principal are known to the agent, N.Y. Public Health Law §2982(2). The legislative caveat quoted by the United States, Govt. Br. 18, merely makes clear that the legislation was not intended as a substantive expansion of the rights recognized by the New York courts. See N.Y. Pub. Health Law § 2989.

Because the line drawn by the State here has endured merely through legislative inertia, this Court's deference is certainly less warranted. Indeed, the lack of evidence of "careful [legislative] consideration" and the doctrines requiring this Court to "avoid unnecessary, or unnecessarily broad, constitutional adjudication," *Thompson v. Oklahoma*, 487 U.S. 815, 857-858 (1988) (O'Connor, J., concurring in judgment), warrant consideration of the approach advocated by Judge Calabresi in the court below. Pet. App. 35a-62a.

York has drawn between those who are on life support and those who are not, the *other* line drawn by the State — in permitting physician assistance in the voluntary ending of the life of a person who is not (yet) on life-sustaining treatment, by the administration of terminal sedation followed by the withholding of nutrition and hydration, see AMA Br. in *Glucksberg* 10 ("sedation and withdrawal of treatment") — renders indisputably and utterly irrational the ban on physician provision, to identically-situated patients, of a simple, life-ending prescription.

Neither petitioners nor their *amici* attempt to defend this extraordinary distinction. Even if the State were found to be appropriately furthering some purpose by banning physician provision, to suffering terminally-ill patients, of requested life-ending prescription drugs while at the same time permitting those on life support to request assistance in the life-ending withdrawal of life-sustaining treatment, New York's regime would not be a rational means of serving any such purpose precisely because it exempts the procedure of physician-administered terminal sedation.

What purpose could possibly be "rationally" furthered by permitting one who is not dependent on life support to seek physician assistance to end his own life — but only if he is willing to do so in a way that is horrific and cruel: by consenting to be made unconscious, rendering him dependent on life support (in the form of artificial nutrition and hydration) if he is to remain alive, and then deliberately causing his own death by having a physician *withhold* it?

The permitted means of assistance — to induce barbiturate coma and then starve the person to death — is gruesome regardless of the patient's anesthetized state. For one who is *not* in a coma to be *rendered* unconscious — in order to permit the atrophy of a week- or two-week-long process of starvation and dehydration — is a profound affront to the dignity of the person. Indeed, this Court has recognized in the Eighth Amendment setting that, even for capital murderers sentenced to be punished by death, a method of ending life that involves "unnecessary pain," *Louisiana* v. *Resweber*, 329 U.S. 459, 463 (1947) (opinion of Reed, J.) or "a lingering death," *In re Kemmler*, 136 U.S. 436, 447 (1890), is unconstitutionally "cruel." See U.S. Const. Amend. VIII.

Literally every interest advanced by the State to defend its

prohibition on the prescription of life-ending drugs is present equally — if not more so — when the physician administers barbiturates to induce what is to be a terminal coma. Yet the State restricts only those who seek the former. There is no rational argument in favor of a legal scheme that permits a dying patient to obtain active assistance to end his life, but only if he does so in a way that is particularly gruesome or terrible or does profound dishonor to the human body and spirit, and that indeed entails a sacrifice of what all would presumably concede to be a constitutional right — the right *not* to be rendered unconscious and dependent.

Surely the State cannot permit assistance in dying only to those patients willing and able to endure the extreme hardship or further suffering involved in accepting terminal sedation. This distinction, drawn but not defended by the State of New York, essentially defines "caprice."[26] Particularly in light of the legal availability of terminal sedation, then, the criminal ban on the prescription of life-ending drugs cannot be upheld as a rational means of furthering any legitimate purpose.

CONCLUSION

The judgments of the Courts of Appeals here and in *Washington* v. *Glucksberg*, No. 96-110, should be affirmed.

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[26] Cf. *Carey* v. *Population Services International*, 431 U.S. 678, 715 (1977) (Stevens, J., concurring in part and concurring in the judgment) ("It is as though a State decided to dramatize its disapproval of motorcycles by forbidding the use of safety helmets. One need not posit a constitutional right to ride a motorcycle to characterize such a restriction as irrational and perverse").

Respectfully submitted,

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